Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 23, 2016	2016_200148_0044	022398-16, 025287-16, 026891-16, 026895-16, 028202-16, 029886-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 15, 16, 17 and 18, 2016

This inspection included six critical incidents; four related to alleged resident to resident sexual abuse, one related to alleged staff to resident abuse and another related to alleged visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Nursing Administration Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, reviewed resident health care records and documents related to the home's investigations, as applicable.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, is complied with.

The home's policy to promote zero tolerance of abuse and neglect of residents, #AM-6.9 effective June 2015, describes that any staff member who witnesses/suspects/hears about an act of abuse or neglect, shall report the incident to the direct manager, DOC or Administrator, after ensuring the resident's immediate safety.

On a specified date, the home's DOC (employed with the home at the time of this incident) received a letter from PSW #102 describing witnessed alleged verbal abuse by PSW#101 toward an identified resident along with other alleged incidents reported to have been observed by other staff members, including PSW #103 and #104. The letter is dated three days prior to when the DOC received the letter, however, the date(s) of the suspected incidents were not all known.

Review of the written information and interviews with staff demonstrate that PSW staff members did not report their suspicions of abuse to the direct manager, DOC or Administrator as per the home's policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff comply with the reporting requirements of the licensee's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Resident #001 has a history of inappropriate sexual behaviours involving co-residents. On a specified weekend date, the resident was observed to make remarks and gestures of a sexual nature to resident #002.

On the same day, the observations were reported to the unit RPN who documented the remarks and gestures in the unit planner, in addition to a progress note in resident #001's health care record.

The charge RN, on duty at the time, observed the unit planner documentation and spoke with the RPN. In an interview with the charge RN, it was reported to the Inspector that at the time she did not understand the information recorded by the RPN to be potential sexual abuse. She further reported that with education provided after the specified weekend date, she now understood that she should have reported the information.

During off site activities on the following date of the observations, the Clinical Care Coordinator (employed at the home, at the time of the incident) read the progress note written by the RPN the previous day. The Clinical Care Coordinator informed the home's Administrator, who then took immediate action in contacting authorities, including the Director.

The charge RN did not immediately report to the Director, reasonable grounds to suspect that abuse of a resident may have occurred. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan

Resident #003 was involved in an alleged abuse with a co-resident #002.

The current plan of care for resident #003, related to safety devices, indicates that as a measure to maintain the safety of resident #003, while in the bedroom, a yellow wander guard (also known as the yellow magnetic band) is to be in place at all times.

On the morning of November 15, 2016, the Inspector observed the activities of resident #003. The resident was noted to wander the unit while entering and leaving his/her room on several occasions. Although a yellow magnetic band is available for use the band was not observed to be in place across the door at any time. Staff were observed to be in the vicinity of the door when the resident was present in the room but made no attempt to place the band across the door.

Issued on this 23rd day of November, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.